WOMAN'S HEALTH OPTIONS

IDENTIFICATION FORM / FOR PROCEDURE

Date: ____________________ Time: ______________

Last Name: ____________________________________ First Name: ________________________________

Preferred Name: _________________________________ Preferred Pronoun: ________________________

Address: ____
(Street)

____
(City/Town) **(Province/Country)** **(Postal Code)**

Date of Birth: _______________________________________ Age: ______________________
Day Month Year

Telephone No.: (_____)______________________ (______)______________________
(Home) (Business)

Telephone Number (other) ____

E-Mail Address ____

Country of Birth: ____

What is your first language? __________________ Driver Name/Ph____

Emergency Contact: ______________________________ ____
(Name) (Phone Number)

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FOR OFFICE USE ONLY

File No: __________________ Date: __________________

Fee: _____________________ U/S Fee: _________________ Receipt No. U\S __________

Paid: ____________________ Receipt No. _______________

Balance: __________________ Depo Evra Nuvaring IUD Visa Cash MC Debit

Province: AB BC SK MB ON NT NU YT NB NS PEI NL RCMP D.N.D. Immigration Visa Cash MC Debit

FAC 87.29A/635 87.29B/635 BM X317 X320 X318 13.99BA/622.1 13.99BE/622.1 03.03A/V26.4

03.04A/V25.9 03.08A/V25.0 81.8/V25.1 87.0A/635 79.29E/622.8 (Biopsy) 79.29E/622.7 (Polyp) 13.59A/626.8

Date appointment booked: ________________________

MEDICAL HISTORY

1. Circle present symptoms of pregnancy: Frequent Urination – Enlarged Breasts – Nausea – Vomiting – Heartburn

2. Did you use Plan B (Morning after pill) to try and prevent this pregnancy? Y / N

3. If it were discovered that you were pregnant with twins would you want to know? Y / N

4. How many previous pregnancies have you had? ________.

5. How many children do you have? ___________. What are their ages? _______________________

   Are you presently breastfeeding? Y / N

   Did you have any problems with previous pregnancies? Y / N If yes, what were they_______________

6. How many vaginal deliveries have you had? ___________

7. Have you had any previous cesarean sections? Y / N If yes, why ______________________________

8. Have you ever had a miscarriage? Y / N If yes, how many __________

9. Have you ever had an ectopic pregnancy (tubal pregnancy)? ___________________

10. Have you ever had an abortion before? Y / N If yes, where and when ___________________________

11. Have you ever had a pap smear / pelvic exam before? Y / N
    If yes, when was your last pap smear? ___________
    Have you ever had an abnormal pap smear? Y / N
    Have you ever had pelvic inflammatory disease or endometriosis? Y / N
    Have you ever had an STI (sexually transmitted infection)? Y / N If yes, was it treated? Y / N

12. Would you like us to test for Bacterial Vaginosis, Gonorrhea, and Chlamydia? Y / N
    Would you like a Pap Smear (cervical cancer screening)? Y / N
    Would you like us to test for Syphilis today? Y / N
    If yes, provide a phone number or email address where you can be contacted. _____________________________
    You will only be contacted if results are positive.

13. Have you ever had a HPV vaccine? Y / N If so when? ____
    Would you like information on that today? Y / N

14. If you are receiving a Depo injection today, when was your last injection? ______________________

15. Have you ever been admitted to a hospital before? Y / N If yes, what for_____________________________

16. Have you ever had surgery on your Uterus, Fallopian Tubes or Cervix? Y / N
    If yes, what type of surgery? ____

17. Have you ever had or do you have any of the following (please circle)? **None** – Epilepsy – Diabetes – Anemia
    High Blood Pressure – Asthma/Hay Fever – Von Willebrand Disease – Bleeding Problems – Hepatitis – Thyroid
    HIV – AIDS – Inflammatory Disease – Renal – Ulcers and Heart Burn – Rapid / Irregular / Heart Rate – Crohn's
    Ulcerative Colitis – Hyper emesis – Liver – Immune Thrombocytopenic Purpura – Other________________________

18. Have you experienced any of the following (please circle)? **None** – Depression – Anxiety / Panic Attacks – Bi-Polar
    FASD – ADHD – ADD – Post Partum Depression – Schizophrenia – Anorexia / Bulimia – PTSD

19. Do you have any allergies that you are aware of? Y / N If yes, see below.

Allergy		**REACTION**	**ALLERGY**		**REACTION**
Penicillin	Y N		Sulfa	Y N	
Tetracycline	Y N		Flagyl	Y N	
Nesacaine	Y N		Gentamicin	Y N	
Xylocaine	Y N		Cipro	Y N	
Lidocaine	Y N		Erythromycin	Y N	
Demerol	Y N		Advil	Y N	
Codeine	Y N		Amoxicillin	Y N	
Morphine	Y N		Ampicillin	Y N	
Tylenol	Y N		Anaprox	Y N	
Latex	Y N		Cytotec	Y N	
Methotrexate	Y N		Remifentanil	Y N	
Fentanyl	Y N		Versed	Y N	
Other					

20. Do you have any environmental or food allergies? Y / N Unknown If yes, please list below

____

21. Are you allergic to anesthesia? Y / N Unknown

22. Do you, or anyone in your family, have malignant hyperthermia (severe over heating of the body generally due to anesthetic)? Y / N Unknown

23. Have you, or any close relative, had a venous thrombosis (blood clot in leg, thigh, lung or pelvis)? Y / N Unknown

24. Please list ANY medications, remedies you take on a daily/regular basis: ____________________________

25. Do you have benefits for prescription drugs? Y / N

26. Do you smoke? Y / N

27. Do you use recreational drugs on a regular basis or have you been heavily dependent in the past? Y / N

If yes, please circle: Speed – Cocaine – Crack, Marijuana – Ecstasy – Mescaline – Crystal Meth – LSD

Methadone – Heroin – Morphine – Alcohol – Other.

Have you used any in the last 24 hours? Y / N If yes, what _________________how much__________________

28. What method of birth control were you using when you became pregnant? ___________________________

29. What method of birth control would you like to use in the future? _________________________________

Birth control requested_______________ Rx Sample / Quick start

1. Whose decision is it for you to have this abortion? ____

2. What would be helpful for you today?

___ Having the procedure explained to me.

___ Getting birth control information.

___ Being able to talk about my feelings with someone.

___ Having my support person with me during the abortion.

___ Does your support person want to speak with a counselor.

___ Getting more information about fetal development.

___ Having something to remember the pregnancy by.

___ Talking about spiritual concerns and /or getting ideas about rituals or ceremonies.

___ Referral for counseling.

___ Do you want a counselor to phone you to follow up on your appointment.

___ Viewing the fetal tissue and remains after the procedure.

___ Taking the fetal tissue and remains after the abortion.

___ I don't want to know about anything today.

We know that violence against women is a problem for many and can directly affect overall and reproductive health. Violence can take many forms; physical, emotional, sexual, financial, psychological, spiritual/religious, or neglect. It can also take the form of threatening to hurt you or someone you love.

3. Are you experiencing violence now or within the last 3 months prior to becoming pregnant? Y / N

4. Do you have any other concerns today? ____

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____

I last ate at: ___________________________ (date/time) I last drank at: ________________________ (date/time)

I HEREBY DECLARE THAT I FILLED OUT THIS FORM TO THE BEST OF MY ABILITY

Date: ____________________________ Signature: ____